APPLICATION FOR PRESCRIPTIVE AUTHORITY FOR A PHYSICIAN ASSISTANT

State Form 53314 (6-07)
Approved by State Board of Accounts, 2007

Reset Form

MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS: *Please type or print clearly in ink.*

*Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

FOR OFFICE USE ONLY		
Amount of fee	Date fee paid (*month, day, year*)	Receipt number
Certificate number issued	Date of issuance (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

PHYSICIAN ASSISTANT INFORMATION

Name (*last, first, middle*)		
Mailing address (*number and street or rural route, city, state, and ZIP code*)		
Social Security number *	Date of birth (*month, day, year*)	Physician Assistant license number
E-mail address	Telephone number ( )	Are you also applying for a Controlled Substances Registration application? ☐ Yes ☐ No

SUPERVISING PHYSICIAN INFORMATION

Name of Supervising Physician	License number
Location of practice *(number and street or rural route, city, state, and ZIP code)*	
Date began employment with current Supervising Physician (*month, day, year*)	

LIST PREVIOUS SUPERVISING PHYSICIANS FOR LAST TWO YEARS (*attach additional sheet, if necessary*)

NAME	LICENSE NUMBER	LOCATION OF PRACTICE	DATE BEGAN EMPLOYMENT	DATE ENDED EMPLOYMENT

PHYSICIAN ASSISTANT DIPLOMA GRANTED BY

Full name of school (*do not abbreviate*)	Date of graduation *(month, day, year)*

Please include proof of thirty (30) contact hours of Pharmacology with your application.

NCCPA CERTIFICATE

NCCPA Certificate number	Date granted *(month, day, year)*	Date of expiration *(month, day, year)*

If your answer is **"yes"** to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event, including the location, date, and disposition. Falsification of any of the following is grounds for permanent revocation of the prescriptive authority issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held in any state or country? ☐ Yes ☐ No
2. Have you ever surrendered or been denied a license, certificate, registration or permit to practice as a health care professional regulated in any state or country? ☐ Yes ☐ No
3. Are there charges pending against you regarding a violation of any Federal, State or local law relating to the use, manufacturing, distribution, or dispensing of controlled substances, alcohol, or other drugs? ☐ Yes ☐ No
4. Are you now being, or have you ever been, treated for drug or alcohol abuse? ☐ Yes ☐ No
5. Have you ever been arrested, convicted, pled guilty, or *nolo contendere to:*
   a. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances, alcohol, or other drugs? ☐ Yes ☐ No
   b. Any offense, misdemeanor, or felony in any state? *(Except for minor violations of traffic laws resulting in fines.)* ☐ Yes ☐ No
6. Have you ever been the subject of an investigation by an authority regulating your profession? ☐ Yes ☐ No

SUPERVISING PHYSICIAN'S STATEMENT

Name of Supervising Physician *(last, first, middle)*	Social security number *
License number	Date license expires *(month, day, year)*
Residence address *(number and street or rural route, city, state, and ZIP code)*	
Office address *(number and street or rural route, city, state, and ZIP code)*	
Residence telephone number ( )	Office telephone number ( ) / E-mail address
Date of birth *(month, day, year)*	Place of birth

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of school	Location	Date of graduation (*month, day, year*)

POST GRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING

INSTRUCTIONS: *Include **all** internships, residencies and / or fellowships in the United States or Canada.*

NAME OF SCHOOL / HOSPITAL	LOCATION	FROM *(month, year)*	TO *(month, year)*

INSTRUCTIONS: *Give a description of your practice, areas of specialization, and / or board certification.*

SUPERVISORY AGREEMENT FOR THE PHYSICIAN ASSISTANT

INSTRUCTIONS: *ON AN ATTACHED SHEET, give a detailed description of the exact privileges and tasks the physician assistant shall be performing under the physician's supervision. In addition, please give a detailed description of the process maintained for evaluation of the physician assistant's performance. THIS SUPERVISORY AGREEMENT MUST BE ON COMPANY LETTERHEAD (including address, telephone number, and fax number), BE PERSON SPECIFIC, AND BE SIGNED BY BOTH THE PHYSICIAN ASSISTANT AND THE SUPERVISING PHYSICIAN, AND COMPLY WITH IC 25-27.5.*

LIMIT ON PHYSICIAN ASSISTANT SUPERVISION

As a supervising physician, I understand that I may supervise no more than two (2) physician assistants. Please indicate below the name and certificate number of the physician assistant(s) you are currently supervising, if any.

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the physician assistant named in this application will be under your continuous supervision in accordance with IC 25-27.5-6 and 844 IAC 2.2, and that you shall review all records of patient encounters maintained by the physician assistant within 24 hours after the physician assistant has seen a patient and at all times retain professional and legal responsibility for the care rendered by the physician assistant.

Signature of supervising physician	Date *(month, day, year)*

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned, requested by the Agency, or any of its authorized representatives in connection with processing my application for supervising physician.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Agency and the Physician Assistant Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date *(month, day, year)*

Please include with this application, on a separate sheet of paper, a letter from your current of former supervising physician attesting to the fact that you have been continuously employed as a physician assistant for not less than one (1) year after graduating from a physician assistant program approved by the Committee. To be considered to have been continuously employed as a physician assistant for one (1) year for purposes of this subsection, a person must have worked as a physician assistant more than one thousand eight hundred (1,800) hours during the year.

The letter must be on letterhead with the name and license number of the supervising physician and must be signed by the supervising physician.